Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
THOMAS DILGER

Respondent Name
LIBERTY MUTUAL INSURANCE CO

MFDR Tracking Number
M4-14-0141-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
September 12, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is a Designated Doctor Exam performed on 11/20/12. Despite multiple attempts to collect on this claim, the insurance carrier is attempting theft of services rendered. The DDE & claim were faxed to the carrier on 11/24/12. Therefore MDR is filed via certified mail with receipt."

Amount in Dispute: $650 + 350 for Interest

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We base our payments on the Texas Fee Guidelines and the Texas Department of Insurance Division of Workers' Compensation Acts and Rules. This claim is not part of the Certified Network. The provider submitted copies of a Fax confirmation showing timely submission. Payment has been processed for the charges of 11/20/2012. A copy of the payment EOB is attached."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 20, 2012	CPT Code 99456-WP-W5 (Maximum Medical Improvement) and 99456-WP-W5 (Imapirment Rating)	$650 + 350 days for Interest	$0.07

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §134.130 sets outs the procedures for Interest for Late Payment on Medical Bills and Refunds
2. 28 Texas Administrative Code §133.240 sets out the procedures for Medical Payments and Denials.

3. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services.
5. Texas Labor Code §413.019 sets out the procedures for Interest Earned For Delayed Payments, Refund, Or Overpayment.
6. Texas Labor Code §401.023 sets out the procedures for Interest or Discount Rate
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
    - No EOB's received

Issues

1. What is the Maximum Allowable Reimbursement (MAR) for disputed service code 99456-WP-W5?
2. What is the interest due per 28 Texas Administrative Code §134.130 for the disputed service?
3. Is the requestor entitled to additional reimbursement

Findings

1. Per 28 Texas Administrative Code §134.204(j)(3)(C) states "An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." In order for the requestor to be reimbursed in accordance with 28 Texas Administrative Code §134.204(j)(3)(C), the requestor was required to perform Maximum Medical Improvement Examination. Review of submitted documentation finds the requestor performed a Maximum Medical Improvement Examination. The maximum allowable reimbursement is $350.00 in accordance with §134.204(j)(3)(C).

   Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II) states "(II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area; and (-b-) $150 for each additional musculoskeletal body area." In order for the requestor to be reimbursed in accordance with 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II), the requestor was required to perform a full physical evaluation with range of motion of the upper extremities. The maximum allowable reimbursement for impairment rating with range of motion to the upper extremities is $300.00.

   The total maximum allowable reimbursement for CPT Code 99456-WP-W5 is 650.00.

   The requestor provided additional information on April 03, 2014 stating partial payment paid on October 17, 2013.

   Review of explanation of benefits provided by the carrier shows a payment for maximum medical improvement and impairment rating paid on September 20, 2013. Additional the carrier paid interest in the amount of $15.51 on September 20, 2013.

   Therefore, the requestor is not entitled to additional reimbursement for CPT Code 99456-W5-WP.
2. The requestor in it's request for Medical Fee Dispute Resolution requested interest. In accordance with 28 Texas Administrative Code §134.130 the amount of $15.58 is interest for the disputed service. However the carrier reimbursed the requestor for interest on September 20, 2013 in the amount of $15.51 leaving a balance due of $0.07. Therefore, additional reimbursement for interest is due to the requestor for $0.07.
3. The division concludes that the total amount for interest is $0.07. The respondent issued payment in the amount of $15.51 for interest. Based upon the documentation submitted, additional reimbursement in the amount of $0.07 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $ 0.07.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $0.07 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	11/20/14 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.